General

Guideline Title

Follow-up and surveillance of curatively treated lung cancer patients.

Bibliographic Source(s)

Ung YC, Souter LH, Darling G, Dobranowski J, Donohue L, Leighl N, Ellis PM, Lung Cancer Follow-up Expert Panel. Follow-up and surveillance of curatively treated lung cancer patients. Toronto (ON): Cancer Care Ontario (CCO); 2014 Aug 29. 90 p. (Evidence-based series; no. 26-3). [41 references]

Guideline Status

This is the current release of the guideline.

The EVIDENCE-BASED SERIES report, initially the full original Guideline, over time will expand to contain new information emerging from their reviewing and updating activities.

Please visit the Cancer Care Ontario Web site for details on any new evidence that has emerged and implications to the guidelines.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Recommendations, Key Evidence, and Justification

Table 1 in the original guideline document summarizes the recommended evaluations and intervals for the routine surveillance of non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC) survivors. These recommendations are based on the expert opinion of the authors, interpretation of the available evidence, and feedback obtained from health care professionals across Ontario through an extensive review process (described in Section 3 of the original guideline document). There is currently no data demonstrating improvements in survival from routine surveillance. There are however clinical options for managing local or locoregional recurrence. Therefore, routine surveillance schedules have been designed in order to detect local or locoregional recurrence and new primary lung cancers that are amenable to salvage therapy in asymptomatic patients during follow-up care. Survivors who develop symptoms suggestive of recurrence, should be evaluated according to those symptoms.

Recommendation 1

Following curative-intent treatment for NSCLC, survivors should receive scheduled follow-up visits that include a medical history, physical examination and chest imaging. Clinical evaluations should be conducted every three months in years 1 and 2, every six months in year 3 and

annually thereafter.

Recommendation 2

Following curative-intent treatment for SCLC, survivors should receive scheduled follow-up visits that include a medical history, physical examination and chest imaging. Clinical evaluations should be conducted every three months in years 1 and 2, every six months in year 3 and annually thereafter.

Recommendation 3

For both NSCLC and SCLC survivors, no recommendation can be made in relation to positron emission tomography (PET)/computerized tomography (CT).

Recommendation 4

In the expert opinion of the authors, any new and persistent or worsening symptom warrants the consideration of a recurrence, especially:

Constitutional symptoms:

- Dysphagia
- Fatigue (new onset)
- Nausea or vomiting (unexplained)
- New finger clubbing
- Suspicious lymphadenopathy
- Sweats (unexplained)
- Thrombosis
- Weight loss or loss of appetite

Pain:

- Bone pain
- Chest pain
- Caveat shoulder pain not related to trauma

Neurological symptoms:

- Headaches (if persistent)
- New neurological signs suggestive of brain metastasis or cord compression such as leg weakness or speech changes
- Headache or focal neurological symptoms

Respiratory symptoms:

- Cough (despite use of antibiotics)
- Dyspnea
- Hemoptysis
- Hoarseness
- Signs of superior vena cava obstruction
- Stridor

Recommendation 5

Health-related quality of life (QoL) is very important for long-term survivors suffering from late side effects of their curative-intent therapy (including surgery, chemotherapy and radiation therapy). The following is a summary of issues reported by survivors. Health care professionals need to aid lung cancer survivors in handling these symptoms to improve QoL.

Constitutional issues:

- Anxiety
- Cough
- Decline in appetite
- Decrease in general health

- Depression
- Dysphagia
- Esophageal stricture
- Fatigue
- Pain
- Physical ability restrictions
- Reduced sleep quality
- Shortness of breath

Long-term chemotherapy effects:

- Hearing loss
- Neuropathies
- Renal impairment

Long-term radiation effects:

- Breathing complications
- Breathlessness/dyspnea

Long-term surgery effects:

- Empyema
- Oxygen dependence
- Post-thoracotomy pain syndrome
- Reduced exercise tolerance or activity limitations
- Shortness of breath

Recommendation 6

For lung cancer survivors who have completed curative-intent therapy, surveillance is required and may be provided by specialists, family physicians or hospital-based nurses.

Recommendation 7

Smoking cessation counseling is recommended for patients who have completed curative-intent therapy for NSCLC and SCLC. Although verbal cessation advice from a health care professional is of benefit, interventions that involve behavioral and pharmacotherapy support in addition to verbal advice is recommended.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Lung cancer

- Small cell lung cancer (SCLC)
- Non-small cell lung cancer (NSCLC)

Guideline Category

Evaluation

Management

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Oncology

Pulmonary Medicine

Radiation Oncology

Radiology

Thoracic Surgery

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Respiratory Care Practitioners

Guideline Objective(s)

- To develop recommendations for optimal clinical and imaging surveillance and disease control after curative-intent treatment for lung cancer
- To assess late toxicity from cancer treatments, quality of life (QoL) of lung cancer survivors and the benefit of smoking cessation interventions
- To determine which test should be done at which intervals for optimal cancer surveillance and control
- To determine what QoL issues are experienced by lung cancer survivors following curative-intent treatment

Target Population

Both small cell lung cancer (SCLC) and non-small cell lung cancer (NSCLC) patients who have received curative-intent treatment

Interventions and Practices Considered

1. Scheduled follow-up visits for curative-intent treatment lung cancer patients (medical history, physical examination, chest imaging)
2. Assessment of symptoms of disease recurrence
3. Management of health-related quality of life (QoL) symptoms
4. Ongoing surveillance
5. Smoking cessation (counseling, behavioral, pharmacotherapy)

Note: Positron emission tomography/computerized tomography (PET/CT) was considered but not recommended.

Major Outcomes Considered

- Health related quality of life symptoms
- Survival (overall and recurrence free)
- Quality of life

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Guideline Review

Almost all Program in Evidence-Based Care (PEBC) document projects begin with a search for existing guidelines that may be suitable for adaptation. The PEBC defines adaptation, in accordance with the ADAPTE Collaboration, as "the use and/or modification of (a) guideline(s) produced in one cultural and organizational setting for application in a different context". This includes a wide spectrum of potential activities from the simple endorsement, with little or no change, of an existing guideline, to the use of the evidence base of an existing guideline with de novo recommendations development.

For this document, a search was conducted of the Inventory of Cancer Guidelines (www.cancerview.ca) and the National Guideline Clearinghouse (www.guideline.gov). In addition, the websites of several known high-quality guideline developers, including Scottish Intercollegiate Guideline Network (SIGN), American Society of Clinical Oncology (ASCO), European Society of Clinical Oncology (ESMO), National Comprehensive Cancer Network (NCCN), American Society for Radiation Oncology (ASTO), European Society for Radiotherapy and Oncology (ESTRO), American Association for Thoracic Surgery (AATS), American Thoracic Society (ATS), European Society of Thoracic Surgeons (ESTS), Society of Thoracic Surgeons (STS) and American College of Chest Physicians (ACCP), were searched. Finally, an electronic search employing OVID was used to systematically search the MEDLINE and EMBASE databases from 2000 to week 49 of 2012 using the following keywords: "lung cancer," "surveillance," "follow up," "after care," "survivor," "recurrence," and "late effects". Only guidelines published after 2000 were considered. Additionally, only the most recent clinical practice guidelines from each organization, when multiple guidelines were found with overlapping outcomes, were chosen for further evaluation. A priori methodology planned that the Appraisal of Guidelines for Research and Evaluation (AGREE II) Instrument would be applied to any clinical practice guideline that was considered for inclusion. Since none of the identified guidelines were incorporated into the evidentiary base of our systematic review (see Section 2 in the original guideline document), AGREE II scores were not calculated for any guidelines.

Search for Existing Systematic Reviews

An electronic search employing OVID was used to systematically search the MEDLINE and EMBASE databases for systematic reviews on the follow-up care of curatively treated lung cancer patients. OVID was searched from 2000 to week 4 of 2014 using the following keywords: "lung cancer," "surveillance," "follow up," "after care," "survivor," "recurrence," and "late effects". In addition, websites/databases of specific guideline developers and systematic review producers were also searched, using the same keywords and for the same time period. These websites/databases included: Cochrane Database of Systematic Reviews (CDSR), Scottish Intercollegiate Guideline Network (SIGN), American Society of Clinical Oncology (ASCO), European Society of Clinical Oncology (ESMO), American Society for Radiation Oncology (ASTO), European Society for Radiotherapy and Oncology (ESTRO), American Association for Thoracic Surgery (AATS), American Thoracic Society (ATS), European Society of Thoracic Surgeons (ESTS), Society of Thoracic Surgeons (STS) and American College of Chest Physicians (ACCP). When multiple reviews were found with overlapping outcomes, only the most recent systematic review was chosen for further evaluation.

Identified systematic reviews that required further consideration based on the criteria above were assessed using the Assessing the Methodological Quality of Systematic Reviews (AMSTAR) tool. The results of the AMSTAR assessment were used to determine whether or not an existing

review could be incorporated as part of the evidentiary base.

Any identified reviews that did not meet the criteria above, whose AMSTAR assessment indicated important deficiencies in quality, or that was otherwise not incorporated as part of the evidence base would be reported in the reference list, but not further described or discussed.

Primary Literature Systematic Review

Assuming that no existing systematic reviews were identified, or that the identified reviews were incomplete in some fashion, a systematic review of the primary literature was also planned. This review was reduced in scope, such as a reduction in subject areas covered, time frames covered, etc., based on the scope of incorporated existing reviews. The criteria described below are written assuming no existing reviews were incorporated.

Literature Search Strategy

OVID was used to systematically search the MEDLINE and EMBASE databases for articles related to follow-up care of curatively treated lung cancer patients, published between 2000 and week 4 of 2014. Due to the variation in the research questions, separate searches were conducted for each question. Common to each search were terms to retrieve articles on lung cancer and survivor follow-up care. A complete literature search strategy for each question (see the "Description of Methods Used to Formulate the Recommendations" for questions) can be found in Appendix 2 in the original guideline document. In addition to the MEDLINE and EMBASE databases searches, reference lists of included systematic reviews and primary literature were scanned for potentially useful studies.

Study Selection Criteria and Protocol

All hits from the OVID literature search were imported into reference management software (EndNote X6), where the citations underwent de-duplication. Table 1 in the original guideline document describes the details of the inclusion criteria and outcome variables for each question addressed in this evidence summary. For each research question, only full publications on patients treated with curative-intent therapy for NSCLC or SCLC were included. However, for Research Question 6, studies that described smoking cessation strategies did not need to limit enrollment to lung cancer survivors. Due to the limited amount of data expected to be found, the Working Group searched for randomized controlled trials (RCTs), as well as non-randomized studies, except for Research Question 5, which only included RCTs data a priori. Letters and editorials, as well as studies not in English, were excluded from the evidentiary base.

A review of the titles and abstracts that resulted from the search was done by one reviewer. For those items that warranted full-text review, one reviewer reviewed each item, and then the list was checked by the entire Working Group. Once the full-text review was completed, the Working Group re-evaluated the types of studies included in the evidence summary and decided to exclude retrospective and case series studies, as well as prospective studies that enrolled fewer than 30 patients. Additionally, studies that enrolled survivors of multiple cancer types and that did not separately analyze lung cancer survivors were excluded.

Number of Source Documents

Quality of Systematic Reviews

Of the 39 systematic reviews identified by the literature search, only 10 met the inclusion criteria, were assessed with the assessment of multiple systematic reviews (AMSTAR) tool and are included in this evidence summary (see Figure 1, Table 2 in the original guideline document).

Literature Search Results

Twenty-one studies were identified that met inclusion criteria (see Figure 1 in the original guideline document).

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction and Assessment of Study Quality and Potential for Bias

Data were extracted from all studies that passed full-text review by one reviewer and checked by the rest of the Working Group. All extracted data and information were audited by an independent auditor. Important quality features, such as study design, lung cancer type, comparison type, group allocation method, and sources of funding were extracted for each study. Since randomized and non-randomized, as well as diagnostic studies were included in this review, no specific quality assessment tool was used. Instead, the above quality features were extracted. For diagnostic studies, the quality features extracted were based on a modified form from the Cochrane Handbook for Systematic Reviews of Diagnostic Test Accuracy. For non-randomized studies, the study designs were defined by the Cochrane Collaborations schema (Handbook Table 13.2a [see the "Availability of Companion Documents" field]). The Working Group anticipated that the non-randomized studies would not carry the weight of randomized trials when creating recommendations, but agreed that this was the best evidence to be found.

Synthesizing the Evidence

Due to the anticipated large variation in study quality and outcomes measured, pooling the data was not planned.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Formation of Guideline Development Working Group

The Survivorship Program of Cancer Care Ontario asked the Program in Evidence-based Care (PEBC) to develop a guideline on follow-up care of lung cancer survivors. In consultation with the Survivorship Program, a Working Group was identified from the Lung Disease Site Group (DSG) membership, plus outside expertise, suggested by the DSG chairs. This Working Group consisted of one radiation oncologist, two medical oncologists, one surgeon, one radiologist, one family physician and one methodologist. The Working Group, Survivorship Program Expert Panel, representatives from the Lung DSG and representatives from the Cancer Imaging Program also formed the Lung Cancer Follow-up Guideline Development Group. This group would take responsibility for providing feedback on the guideline as it was being developed and acted as Expert Panel for the document at Internal Review, reviewing the document and requiring changes as necessary before approving it.

In order to make recommendations as part of a clinical practice guideline, the Working Group of the Lung Cancer Follow-up Guideline Development Group developed this evidentiary base upon which those recommendations are founded. Based on the objectives of the guideline, the Working Group derived the research questions outlined below.

Research Questions

In survivors who have received curative-intent treatment for non-small cell lung cancer (NSCLC) or small cell lung cancer (SCLC):

1. What clinical activities are effective at detecting recurrence or progression of lung cancer, including detection of metastases in lung cancer survivors?
2. What is the relationship between frequency and timing of any diagnostic/laboratory test in the management of recurrence in lung cancer survivors? Are recurrences associated with symptomatic versus asymptomatic presentation?
3. What symptoms are indicative of possible recurrence or development of any other primary cancer that warrant further evaluation?
4. What are the common non-recurrence related issues experienced by lung cancer survivors?
5. Is there a relationship between the clinician and/or setting of follow-up care and the effective detection and management of recurrent or metastatic disease?
6. Is there a value to smoking cessation counseling for lung cancer survivors?

Methods

This evidentiary base was developed using a planned two-stage method, summarized here and described in more detail below.

1. Search and evaluation of existing systematic reviews: If one or more existing systematic reviews were identified that addressed the research questions and were of reasonable quality, then those systematic reviews formed the core of the evidentiary base.
2. Systematic review of the primary literature: This review focused on those areas not covered by existing reviews if any were located and accepted.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Internal Review

Almost all Program in Evidence-based Care (PEBC) documents undergo internal review. This review is conducted by the Expert Panel and the Report Approval Panel (RAP). The Working Group was responsible for incorporating the feedback and required changes of both of these panels, and both panels had to approve the document before it could be sent to External Review.

Expert Panel Review and Approval

The Lung Cancer Follow-up Expert Panel acted as the Expert Panel for this document. The document must be approved by formal vote. In order to be approved, 75% of the Lung Cancer Follow-up Expert Panel membership must cast a vote or abstain, and of those who voted, 75% must approve the document. At the time of the voting, the Lung Cancer Follow-up Expert Panel members could suggest changes to the document, and possibly make their approval conditional on those changes. In those cases, the Working Group was responsible for considering the changes, and if those changes could be made without substantially altering the recommendations, the altered draft would not need to be resubmitted for approval.

The Lung Cancer Follow-up Expert Panel reviewed the draft document over a six-week period at the end of 2013. During this review the Lung Cancer Follow-up Expert Panel provided key feedback. In response to this feedback, the Working Group made the changes (see the original guideline document).

Report Approval Panel Review and Approval

The purpose of the RAP review is to ensure the methodological rigor and quality of PEBC documents. The RAP consists of nine clinicians with broad experience in clinical research and guideline development, and the Director of the PEBC. For each document, three RAP members review the document: the Director and two others. RAP members must not have had any involvement in the development of the guideline prior to Internal Review. All three RAP members must approve the document, although they may do so conditionally. If there is a conditional approval, the Working Group is responsible for ensuring the necessary changes are made, with the Assistant Director of Quality and Methods, PEBC, making the final determination that the RAP's concerns have been addressed.

In December 2013 the RAP reviewed this document. The RAP approved the document on January 17, 2014 (see the original guideline document for the Key issues raised by the RAP and the Working Group changes made in response to the RAP review).

External Review by Ontario Clinicians and Other Experts

The PEBC external review process is two-pronged and includes a targeted peer review that is intended to obtain direct feedback on the draft

report from a small number of specified content experts and a professional consultation that is intended to facilitate dissemination of the final guidance report to Ontario practitioners.

Following approval of the document at Internal Review, the Lung Cancer Follow-up Expert Panel circulated the draft document with recommendations modified as noted under Internal Review, above, to external review participants for review and feedback.

Methods

Targeted Peer Review

During the guideline development process, nine targeted peer reviewers from Ontario considered to be clinical and/or methodological experts on the topic were identified by the Working Group. Several weeks prior to completion of the draft report, the nominees were contacted by email and asked to serve as reviewers. Five reviewers agreed and the draft report and a questionnaire were sent via email for their review. The questionnaire consisted of items evaluating the methods, results, and interpretive summary used to inform the draft recommendations and whether the draft recommendations should be approved as a guideline. Written comments were invited. The questionnaire and draft document were sent out on April 9, 2014. Follow-up reminders were sent at two weeks (email) and at four weeks (telephone call). The Lung Cancer Follow-up Expert Panel reviewed the results of the survey.

Professional Consultation

Feedback was obtained through a brief online survey of health care professionals who are the intended users of the guideline. The PEBC database was used to identify professionals who had reported being interested in both lung cancer and either survivorship, systemic therapy, radiation, surgery, primary care, imaging, nursing, or post-treatment follow-up. Additionally, lung cancer survivors were identified through Lung Cancer Canada. All identified professionals and survivors were contacted by email to inform them of the survey. Of the 126 individuals informed of the survey, 114 were from Ontario, with the other 12 from other provinces. Participants were asked to rate the overall quality of the guideline (see Section 1 in the original guideline document) and whether they would use and/or recommend it. Written comments were invited. Participants were contacted by email and directed to the survey website where they were provided with access to the survey, the guideline recommendations (see Section 1 in the original guideline document), and the evidentiary base (see Section 2 in the original guideline document). The notification email was sent on April 9, 2014. The consultation period ended on May 9, 2014. The Lung Cancer Follow-up Expert Panel reviewed the results of the survey.

Conclusion

This Evidence-Based Series (EBS) report reflects the integration of feedback obtained through the external review process with final approval given by the Lung Cancer Follow-up Expert Panel and the Report Approval Panel of the PEBC. Updates of the report will be conducted in accordance with the PEBC Document Assessment and Review Protocol.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

High-quality literature for this topic was very limited. As such, many of the recommendations are based on clinical standards and expert opinion.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Optimal clinical and imaging surveillance and disease control after curative-intent treatment for patients with lung cancer
- The three systematic reviews and one cohort study that evaluated the benefits of smoking cessation after diagnosis of lung cancer or prior to surgery all concluded that smoking cessation improved clinical outcomes.

Potential Harms

Qualifying Statements

Qualifying Statements

- Selection of an appropriate imaging modality should reflect the competing risk of locoregional recurrence, which is potentially curative versus distant recurrence, which is not curative. A cohort study and the National Lung Screening Trial indicated that minimal-dose computerized tomography (MnDCT) and low-dose CT (LDCT) detect pulmonary lesions better than chest x-ray, yet no demonstrated survival benefit has been established in patients treated by surgical resection with curative intent. Thus, for routine surveillance, LDCT or MnDCT without intravenous (IV) contrast may be a reasonable option instead of chest x-ray. The MnDCT cohort study conducted chest CTs at three months post-treatment, followed by six months post-treatment, then at six month intervals until the end of year 2, followed by annually until year. As this is the best available schedule at this time, the intervals are considered reasonable, with the addition of annual surveillance exceeding year 5, as outlined in the Justification section of the original guideline document. Even though surveillance is recommended annually until end of life, health care professionals should use their own discretion in determining the applicability of annual surveillance in patients who are not well enough to undergo treatment if a new cancer is detected. When recurrent disease or new disease is suspected, either from constitutional symptoms or chest imaging findings, diagnostic chest CT plus upper abdomen CT scan is suggested to identify local recurrence or a new lung primary.
- Selection of an appropriate imaging modality should reflect the competing risk of locoregional recurrence, which is potentially curative versus distant recurrence, which is not curative. Based on the clinical experience of the Working Group and results from the National Lung Screening Trial, for routine surveillance, diagnostic CT without IV contrast is preferable to chest x-ray for detection of pulmonary lesions, though no survival benefit has been established. Also based on the clinical experience of the Working Group, diagnostic CT with contrast is suggested for detection of recurrence in mediastinal lymph nodes. In the expert opinion of the Working Group, CT imaging may be conducted three months post-treatment, followed by six months post-treatment, then at six month intervals until the end of year 2, followed by annually thereafter. Beyond year 2, LDCT or MnDCT could be considered rather than a diagnostic CT. Even though surveillance is recommended annually until end of life, health care professionals should use their own discretion in determining the applicability of annual surveillance in patients who are not well enough to undergo treatment if a new cancer is detected. When recurrent disease or new disease is suspected, either from constitutional symptoms or chest imaging findings, diagnostic chest CT plus upper abdomen CT scan is suggested to identify local recurrence or a new lung primary.
- Although the identified literature only evaluated hospital-based nurse-led care models, expert opinion supports family physician-led care models. Additionally, family physicians should be included in all survivorship care models. There is no evidence to support timing for when lung cancer survivors can be transitioned into non-specialist care, thus no recommendation can be made for when transition is appropriate.
- Care has been taken in the preparation of the information contained in this report. Nonetheless, any person seeking to apply or consult the report is expected to use independent medical judgment in the context of individual clinical circumstances or seek out the supervision of a qualified clinician. Cancer Care Ontario makes no representation or guarantees of any kind whatsoever regarding the report content or use or application and disclaims any responsibility for its application or use in any way.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

IOM Domain

Effectiveness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Ung YC, Souter LH, Darling G, Dobranowski J, Donohue L, Leighl N, Ellis PM, Lung Cancer Follow-up Expert Panel. Follow-up and surveillance of curatively treated lung cancer patients. Toronto (ON): Cancer Care Ontario (CCO); 2014 Aug 29. 90 p. (Evidence-based series; no. 26-3). [41 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2014 Aug 29

Guideline Developer(s)

Program in Evidence-based Care - State/Local Government Agency [Non-U.S.]

Guideline Developer Comment

The Program in Evidence-based Care (PEBC) is a Province of Ontario initiative sponsored by Cancer Care Ontario and the Ontario Ministry of Health and Long-Term Care.

Source(s) of Funding

The Program in Evidence-based Care (PEBC) is supported by the Ontario Ministry of Health and Long-Term Care through Cancer Care Ontario. All work produced by the PEBC is editorially independent from its funding source.

Guideline Committee

Working Group of the Lung Cancer Follow-up Guideline Development Group

Composition of Group That Authored the Guideline

Authors: Y.C. Ung, L.H. Souter, G. Darling, J. Dobranowski, L. Donohue, N. Leighl, P.M. Ellis

Financial Disclosures/Conflicts of Interest

In accordance with the Program in Evidence-based Care (PEBC) Conflict of Interest (COI) policy, the guideline authors, Lung Cancer Follow-up Expert Panel members, and internal and external reviewers were asked to disclose potential conflicts of interest. All authors and internal reviewers declared they had no conflicts of interest. For the Expert Panel, 14 members declared they had no conflict of interest, and one (MR) declared a conflict. MR reported receiving $10,000 in 2011 for consulting on lung cancer follow-up. The conflict of interest declared by MR did not disqualify the individual from performing her role in the development on this guideline, in accordance with the PEBC COI Policy. All external reviewers declared that they had no conflict of interest. To obtain a copy of the policy, please contact the PEBC office by email at ccopgi@mcmaster.ca.

Guideline Status

This is the current release of the guideline.

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Please visit the Cancer Care Ontario Web site for details on any new evidence that has emerged and implications to the guidelines.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Available from the Cancer Care Ontario Web site.

Availability of Companion Documents

The following are available:

- Follow-up and surveillance of curatively treated lung cancer patients. Summary. Toronto (ON): Cancer Care Ontario; 2014 Aug 29. 15 p. Electronic copies: Available from the Cancer Care Ontario (CCO) Web site.
- Program in evidence-based care handbook. Toronto (ON): Cancer Care Ontario (CCO); 2012. 14 p. Available from the CCO Web site.

Patient Resources

None available

NGC Status

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